Executive summary

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Medicare beneficiaries living in rural areas face many barriers to getting the medical care they want and need. Some barriers relate to distance and population density, and others to economic conditions—all may vary widely over the broad spectrum of conditions in rural areas. Providers, especially specialists, are relatively scarce in rural areas and the financial burden of obtaining care is often greater for rural than for urban beneficiaries because they tend to have lower incomes and less supplemental insurance or access to Medicare+Choice coordinated-care plans.

Despite these barriers, rural Medicare beneficiaries do not seem to be measurably disadvantaged compared with urban beneficiaries. The Commission's analyses suggest that they are about as likely to get needed care, just as satisfied with the care they receive, and use about as much health care on average as their urban counterparts, albeit a slightly different mix of services. Overall, rural beneficiaries and providers have adapted to and often overcome barriers in rural areas, although not without some inconvenience and cost. When necessary, beneficiaries travel to more urban areas for needed specialized care and specialists travel to rural areas.

However, not all barriers can be overcome. Many rural providers are experiencing financial hardship, and providers may not be able to remain in markets in which economic and demographic conditions are especially unfavorable. In those cases Medicare may not be the sole, or even the principal, problem.

The fragility of the rural health care system calls for continued vigilance and special care to ensure that Medicare policies do not weaken rural medicine inadvertently and that, where appropriate, they reflect the special circumstances confronting rural beneficiaries and providers. Following this path, we recommend a number of incremental changes in Medicare that will improve the accuracy of Medicare payments by recognizing factors such as the volume of services that affect the costs of providing care in rural areas. Implementing these recommendations should improve the financial standing of many rural providers. We also recommend changes that may improve access for some financially disadvantaged beneficiaries and improve oversight of the quality of care.

In the Balanced Budget Refinement Act of 1999, the Congress required the Medicare Payment Advisory Commission to study and report on the adequacy and appropriateness of Medicare's payment policies for services furnished by various types of providers located in rural areas. This report examines the Congress' questions and how Medicare is working for rural beneficiaries. Although we focus primarily on payment and other policies in Medicare's traditional program, we also examine issues affecting rural beneficiaries' access to health plans in the Medicare+Choice program.

Medicare and rural health care: overview and challenges for policymakers

Policymakers and rural health care advocates have long been concerned that Medicare beneficiaries and others living in rural areas may not receive the care they need. The geographic isolation, low population density, and poor economic conditions in many rural areas impose economic hardships on providers and make it difficult to attract health professionals. In Chapter 1 we describe those concerns, how market conditions vary among rural areas, and how those variations affect rural providers and beneficiaries. Our analyses confirm that some rural communities face adverse economic conditions that may limit providers' abilities to furnish needed services. Nevertheless, Medicare beneficiaries in rural areas receive similar amounts of health services, on average, as do urban beneficiaries. Although similar use rates do not guarantee that rural and urban beneficiaries receive equally appropriate and effective care, this finding suggests that

major new Medicare policy interventions may not be needed to preserve rural beneficiaries' access to high-quality care. Some incremental changes may be helpful in better adapting Medicare's policies to rural market conditions. Because the stresses facing rural providers often reflect broader market conditions, however, Medicare policy changes alone may not be enough to resolve them fully.

Rural beneficiaries' access to care

Promoting beneficiaries' access to medically necessary health care of high quality is one of the primary objectives of the Medicare program. Rural areas of the country are believed to present more obstacles to beneficiaries' access than more urban areas. However, in Chapter 2 we show that on numerous measures, including satisfaction with availability of providers, ease of getting care, and frequency of receiving needed care, rural and urban beneficiaries appear strikingly similar. Although beneficiaries in the most remote areas report somewhat greater barriers to accessing care, in general rural beneficiaries do not appear to be singularly disadvantaged relative to urban beneficiaries. Overall, rural beneficiaries' greatest potential barrier to care appears to be the cost of care, which may be related to the limited number of rural beneficiaries with supplemental insurance. The Commission is concerned about this problem and recommends identifying strategies to increase eligible rural beneficiaries' participation in government cost-sharing assistance programs. Interpreting the larger policy implications of these findings is complex. Have the programs designed to address the availability of rural providers been successful, or have the barriers to access in rural areas been overestimated and the resourcefulness and adaptability of beneficiaries and providers underestimated? As these issues are further examined, the findings suggest that policymakers should remain vigilant in monitoring access issues in remote rural areas.

Quality of care in rural areas

In the past, rural quality of care issues have received little attention in Medicare policymaking. In Chapter 3, we present largely encouraging results on rural quality of care, but also point to some problems with Medicare's systems for improving and safeguarding quality in rural areas. Quality of care, as measured by the use of recommended services, is roughly comparable among rural counties of varying proximity to metropolitan areas, as well as between rural and metropolitan areas. However, a considerable proportion of beneficiaries in both rural and urban areas are not receiving recommended services. Consequently, the Commission recommends strengthening Medicare's systems for influencing quality in rural areas by requiring the peer review organizations to include rural populations and providers when carrying out their quality improvement activities, and by surveying at least one-third of each facility type annually to certify compliance with the conditions of participation in Medicare.

Improving payment for inpatient hospital care in rural areas

The financial status of rural hospitals continues to be a source of concern for policymakers. Rural hospitals have had lower Medicare inpatient margins than urban hospitals throughout the 1990s, and the gap has widened from less than a percentage point in 1992 to 10 percentage points in 1999. This pattern applies not just to inpatient care but across all major lines of Medicare business, with rural hospitals' overall Medicare margin dipping below zero. This growing imbalance in Medicare financial performance has occurred despite special programs targeted to rural hospitals with specific characteristics such as rural referral, Medicare dependent, critical access, and sole community hospitals. Although some of the difference in performance may be within hospitals' control, the size of the gap suggests that the payment system does not recognize factors that have a greater effect on the costs of rural hospitals, and perhaps overemphasizes those with a greater effect on urban hospitals.

In Chapter 4 we recommend addressing these problems by improving the existing prospective payment system to match payments better to efficient providers' costs, rather than by moving further toward cost-based payment. We identify aspects of Medicare's prospective payment system for inpatient hospital care that tend to work against rural hospitals and recommend several incremental improvements. First is to develop a graduated adjustment to the rates used in the inpatient prospective payment system for hospitals with low overall volumes of discharges. Second is to implement fully the policy of excluding teaching physicians, residents, and certified registered nurse anesthetists from the hospital wage index. Third is to reexamine the proportion of providers' costs assumed to reflect resources purchased in local markets in the wage index. The second and third actions will raise the relative wage index values for most rural hospitals. We also recommend raising the cap on the disproportionate share add-on a rural hospital can receive from 5.25 percent to 10 percent. These first four recommendations would improve the accuracy of the inpatient prospective payment system and better account for differences in market circumstances among hospitals. Finally, we recommend requiring that rural referral centers' wages exceed the average wage in their area to qualify for geographic reclassification. After these recommendations have gone into effect, the results should be evaluated before additional steps are taken.

The Congress also required the Commission to analyze unit costs at psychiatric facilities that are exempt from the prospective payment system. We found that government-owned facilities—which treat a more disabled beneficiary population and one that is more likely to be involuntarily committed—are disadvantaged by the current payment system because it does not recognize these differences in population characteristics. We also found that rural hospital-based psychiatric units appear to have higher unit costs. We recommend revising the current payment system's target cap in a way that better addresses differences among inpatient psychiatric facilities.

Assessing payment for outpatient hospital care in rural areas

Do rural hospitals face special circumstances that make the new outpatient prospective payment system inappropriate for them? If rural hospitals have high costs for providing outpatient services, the new payment system will not adequately cover their costs to provide care because it pays rates based on median costs for all hospitals. In Chapter 5, we evaluate whether special circumstances make it difficult for rural hospitals to keep their costs below the prospective payment system rates. The available evidence suggests that rural hospitals do face some unique circumstances, and may merit special consideration. They rely more on Medicare and on outpatient services as sources of revenue than do urban hospitals, increasing their exposure to the financial risks of prospective payment. At the same time, they tend to have limited administrative capacity and financial reserves, hence limited ability to manage financial risk. Finally, available cost data suggest that rural hospitals have higher outpatient unit costs. Our analysis suggests that in the short term, the existing hold-harmless policy—which provides additional payments to rural hospitals with 100 or fewer beds that experience losses under the outpatient prospective payment system—will provide financial support to rural hospitals that need it. In the longer term, when better information on hospitals' experience with the new payment system is available, other policies may be warranted.

Prospective payment for home health services in rural areas

Should rural home health services be exempt from the new prospective payment system? Rural health care advocates, among others, have suggested that the new payment system may not adequately account for unique conditions in rural areas. Lack of experience with the new system and other data limitations prevent a direct comparison of the costs in rural and urban areas. However, we conclude in Chapter 6 that the components of the new payment system should work equally well in rural and urban areas. Accordingly, we

recommend that rural home health services not be exempt from the prospective payment system. We also recommend that data collection be improved to assess whether any higher costs associated with providing home health services in rural areas are adequately taken into account.

Bringing Medicare+Choice to rural America

Why are Medicare+Choice benefit packages that include extras such as low cost sharing and prescription drugs available to beneficiaries in some urban areas but not widely available to those in rural areas? Despite efforts of the Congress to attract Medicare+Choice managed-care plans to rural areas by revising the payment structure, few such plans are available in rural areas, and the benefit packages they bring with them are not as generous as those offered in some urban areas. In Chapter 7, we conclude that the basic market characteristics shared by many rural areas—including a limited number of providers and a dispersed population—will likely continue to frustrate those efforts because they make it difficult for plans to generate sufficient efficiencies or provider discounts to fund generous benefit packages. A non-network, private fee-for-service option has become available in some rural areas, but (like other options discussed in the chapter) it, too, is unlikely to generate efficiencies or provider discounts, and therefore can only bring generous benefit packages to rural beneficiaries by inappropriately increasing Medicare program costs.

Reviewing the estimated payment update for physician services

Medicare payments for physician services are updated annually based on the sustainable growth rate system, which is designed to control overall spending. Chapter 8 fulfills the Commission's mandate to review the Health Care Financing Administration's (HCFA's) preliminary estimate of the update for 2002. The Commission concludes that the agency's current estimate of the update, −0.1 percent, appears reasonable. As required by law, the agency will revise the estimate and issue a final update this fall. The Commission notes that the final update for 2002 may be lower, perhaps significantly lower, than HCFA's current estimate, which may raise concerns about the adequacy of payments and beneficiary access to care. Such an update would limit physician spending for the first time since enactment of the sustainable growth rate system and illustrates the Commission's concern that updates under the system are not closely related to the cost of providing physician services. Therefore, the Commission reiterates its recommendation to replace the sustainable growth rate system with an update method that better accounts for the cost of providing care, and that policymakers should consider alternatives to that system if spending control is necessary. ■